FERRY COUNTY PUBLIC HOSPITAL DISTRICT #1
CHARITY CARE POLICY

It is the policy of Ferry County Public Hospital District #1 to provide essential services regardless of the Patient's ability to pay.

The District will offer Charity Care using the Federal Poverty Guidelines. See attached guidelines. Exemptions from Standard – Catastrophic hospitalization cost or other patient specific circumstances may justify granting charity care, even when a patient exceeds the indigent standards.

All District employees will be educated to have a full understanding of the Charity Care Policy. Employees will have a yearly educational update, so employees are able to give current information to patients. Verification of Charity Care Policy education will be included in employee's personnel file.

Charity care application and information will be included with discharge planning from hospital care and emergency room services. Notice of availability of Charity Care will be included on all statements sent from the District.

Charity Care applications will be available at all times in all public areas and patient treatment areas and may be filled out for services rendered at any time. Signs will be posted prominently in public areas of the District.

Financial counseling and help with filling out the Application as needed is available by office personnel during business office hours 8:00 a.m. to 5:00 p.m. Monday through Friday.

All applications for Charity Care must be filled out completely and include required documentation. The application will be returned to the financial representative of the District. The financial representative will verify all information.

The hospital administration will receive the verified information and make a determination of eligibility based on Federal Poverty Guidelines using the following criteria:

- Annual income minus allowance of $500.00 per month for housing
- Number of dependents

A letter with the results of the final determination of the Charity Care Application will be sent to the Patient/Guardian within ten (10) working days of receipt of complete application. The District will retain copies of documentation with the application whether approved or denied.

The final determination may be appealed by the Patient/ Guardian within 30 days of the determination. If this determination affirms the previous denial of charity care, written notification will be sent to the patient/responsible party and the Department of Health.

FERRY COUNTY PUBLIC HOSPITAL DISTRICT #1
36 KLONDIKE RD
REPUBLIC WASHINGTON
509 775-3333

Ferry County Public Hospital District #1 provides medical care to anyone, regardless of ability to pay.

CHARITY CARE: HELP FOR FAMILIES WITH HOSPITAL EXPENSES!

WHAT IS CHARITY CARE? Charity Care is a way to help people and families pay for hospital medical services. Charity Care is either free care or reduced price care, depending on your income.

WHO IS ELIGIBLE FOR CHARITY CARE? People and families with incomes within federal poverty guidelines are eligible for Charity Care if they:

1. Do not have the financial resources to pay for care; and
2. Are not insured or under-insured, that is covered by a group or individual medical plan, worker's compensation, Medicare, Medicaid, or any other state, federal, or military program; and
3. Are not involved in a situation where someone else has a legal responsibility to pay for the costs of medical services--- for example, an auto accident.

Important note: Ferry County Public Hospital District #1 does not discriminate based on age, race, color, national origin, religion, sex, handicap or disability.

WHAT DOES CHARITY CARE COVER? Charity Care covers necessary or emergency hospital care. It covers inpatient and outpatient hospital care.

It does not cover transportation costs or elective procedures.

HOW DO I APPLY? To find out what is needed to prove you are eligible and what services will be covered, please contact:

FCPHD#1 Business Office
36 Klondike Rd
Republic, Washington 99166
509 775-3333

FERRY COUNTY PUBLIC HOSPITAL DISTRICT #1

CHARITY CARE APPLICATION

It is the policy of Ferry County Public Hospital District #1 (the District) to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon the household income and size. A sliding fee schedule is used to calculate the basic discount and is updated each year using the federal poverty guidelines.

CHARITY CARE OR PARTIAL CHARITY CARE DOES NOT INCLUDE ELECTIVE OR COSMETIC PROCEDURES.

APPLICATION for Charity Care or Partial Charity Care is to be completed and signed by the patient (or the patient's guardian), if patient is unable to sign the application. All information given to Ferry County Public Hospital District #1 will be considered CONFIDENTIAL.

REQUIRED DOCUMENTATION:

IRS tax return
Social Security Income verification
Notarized proof of no income
Unemployment compensation determination
Medicaid denial
Proof of dependants
Statements of accounts owing
Payroll check stubs
Other information, as required

In the event that the responsible party is not able to provide any of the documentation described above, the District shall rely upon written and signed statements from the responsible party for making a final determination of the eligibility for classification as an indigent person. (WAC 246-453-030(4)

The Applicant may be requested to furnish additional information or documentation before final determination is made.

Ferry County Public Hospital District #1 will verify from listed references and credit reporting agencies any information given on the application.

Ferry County Public Hospital District #1 will send you a letter within 10 business days with the results of your Charity Care or partial Charity Care Application.

The District will retain copies of documentation with the application whether approved or denied.

FERRY COUNTY MEMORIAL PUBLIC HOSPITAL DISTRICT #1
36 Klondike Road
Republic, WA 99166

APPLICATION FOR CHARITY CARE

DATE OF REQUEST_____

AS PROVIDED FOR DISTRICT POLICY I HEREBY REQUEST THAT FERRY COUNTY PUBLIC HOSPITAL DISTRICT #1 MAKE A WRITTEN DETERMINATION OF MY ELIGIBILITY FOR CHARITY CARE OR PARTIAL CHARITY CARE FOR SERVICES AT FERRY COUNTY PUBLIC HOSPITAL DISTRICT #1. **I ALSO UNDERSTAND THAT IF THE INFORMATION WHICH I SUBMIT IS DETERMINED TO BE FALSE, OR INCOMPLETE SUCH A DETERMINATION WILL RESULT IN A DENIAL OF CHARITY CARE OR PARTIAL CHARITY CARE. FOR ASSISTANCE FILLING OUT THIS FORM CALL FPHD#1 BUSINESS OFFICE 509 775-8338.**

PLEASE PRINT

NAME:_____ _____
First Middle Last Spouse's

ADDRESS:_____
Street City State zip+4

BIRTH DATE: _____ SS#_____-_____-_____TELEPHONE:(___)_____

OCCUPATION:_____

EMPLOYER: _____(___)_____
Name City State Phone

SPOUSE'S EMPLOYER:_____(___)_____
Name City State Phone

DO YOU HAVE MEDICAL INSURANCE? _____ _____
Yes No

INSURANCE CARRIER:_____
Name Policy # GROUP#

BILLING ADDRESS:_____
Street City State zip+4

TELEPHONE (_____)_____

(Including yourself) NUMBER OF DEPENDENTS: _____

HAVE YOU ATTEMPTED TO GET AID FROM ANOTHER SOURCE? (i.e DSHS, Basic Health, VA, OTHER)? _____ _____
YES NO

IF YES, GIVE DETAILS (i.e. Agency, contact person, date, etc)

_____

_____

If no, to proceed with your request, other sources must be ruled out. Contact the FCPHD# 1 business office for further assistance.

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PAGE 2 OF APPLICATION FOR CHARITY CARE

INCOME: Approximate Monthly Income from:

SALARY:	_____ Yours	_____ Spouse	PENSION:	_____ Yours	_____ Spouse
SOCIAL SECURITY:	_____ Yours	_____ Spouse	DISABILITY:	_____ Yours	_____ Spouse
DIVIDS/TRUST/RENTS:	_____ Yours	_____ Spouse	CHILD SUPPORT:	_____ Yours	_____ Spouse
DSHS./UNEMPLOYMENT:	_____ Yours	_____ Spouse	OTHER	_____ Yours	_____ Spouse

I AUTHORIZE FERRY COUNTY PUBLIC HOSPITAL DISTRICT #1 TO OBTAIN SUCH INFORMATION AS MAY BE REQUIRED (SEE INSTRUCTIONS FOR ACCEPTABLE VERIFICATION) CONCERNING THE STATEMENTS MADE IN THIS APPLICATION. I AGREE THAT THE APPLICATION SHALL REMAIN THE PROPERTY OF FERRY COUNTY PUBLIC HOSPITAL DISTRICT #1 WHETHER IT IS APPROVED OR NOT. **I HEREBY CERTIFY THAT ALL STATEMENTS MADE AND THE DOCUMENTATION FURNISHED BY ME, ARE TRUE AND COMPLETE, AND ARE MADE FOR THE PURPOSE OF OBTAINING CHARITY CARE OR PARTIAL CHARITY CARE.** I FUTHER AGREE TO SUBMIT SUCH ADDITIONAL DOCUMENTATION THAT MAY BE REQUESTED CONCERNING MY FINANCIAL SITUATION.

_____ _____

Signature Date

Return this application and documentation to: Arlette – Patient Accounts
Ferry County Memorial Hospital
36 Klondike Road
Republic, Washington 99166
509 775-8338

Ferry County Public Hospital District #1
Application reviewed by _____ **% of forgiveness** _____
Application approved on _____ **Requestor is responsible for** _____**%**

Revised 6-22-2006